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Inland Hospital –Medication Monitoring Policies (Developed 2011)

Patient Information

For: Don C. Bassett

Medication Agreement - Inland

I understand that I have a chronic medical problem that may require a prescription to increase my functioning. Sometimes patients need strong pain medications, such as narcotics, anti-anxiety medications (benzodiazepines), and ADHD medications (amphetamines). While these medications are useful to control these conditions, they have the potential to be addictive, cause physical dependency and can be overused and/or abused. Because of this, the government and my provider closely monitor how these medications are prescribed. It is extremely important that I fully understand the proper uses of these medications and the need to protect my medications from being misused by others.

I, Don Bassett, DOB: 06/12/1947 , agree to the following:

1) I will get prescriptions for my medications only from the following provider: Kelly G. Starr MD
2) I will have all prescriptions filled at the following pharmacy: .
3) I understand that my prescription will be provided on a 28 day basis.
4) I will not increase my medication without the approval of my healthcare provider.
5) I understand that the **main treatment goal is to improve my ability to function and/or work.** In consideration of this goal, and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits: exercise, weight control, avoidance of the use of tobacco and alcohol and by attending counseling if indicated. I must also comply with the treatment plan as prescribed by my provider. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
6) **My provider's office will be the only source of my controlled substances.** Should this not be possible, i.e., in an "emergency" or during hospitalization, and I require prescription(s) from another source, it is my responsibility to notify my provider's office. The amount of narcotic medications prescribed, the reasons additional medication was needed, and the length of therapy or hospitalization must be given. Failure to report the above is a breach of this agreement.
7) **Refills will be made only during regular office hours**, Monday through Friday, and require 2 business days' notice. Refills may not be made at night, on weekends, or during holidays.
8) **Refills will not be made** if I "run out early", "lose a prescription", "spill or misplace my medication" or for any other similar reason. I am responsible for taking the medication in the dose prescribed.
9) My provider's office will not be responsible for any prescriptions once they have left the office.
10) It is my responsibility to be discreet about possessing narcotics and to keep medications in an inaccessible place so that they will not be lost or stolen. Misplaced, lost or accidentally destroyed medications or prescriptions ***will not be replaced.*** I further understand that if my medications are stolen, I must immediately file a complaint with

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_____ Date:_____

Staff Acknowledgement